ZRC MEDICAL RESOLUTIONS INC

REVIEWER'S REPORT

DATE OF REVIEW: 03/15/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Ten days of a chronic pain management program

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:
M.D., Board Certified in Anesthesiology by the American Board of Anesthesiology with Certificate of Added Qualifications in Pain Management, in practice of Pain Management full time since 1993

REVIEW OUTCOME:
"Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

__X __Upheld (Agree)

_____Overturned (Disagree)

_____Partially Overturned (Agree in part/Disagree in part)

The ODG Guidelines for a chronic pain management program have not been met.

INFORMATION PROVIDED FOR REVIEW:

1. TDI referral
2. URA records, 1/6 to 24//2010
3. Health Care, office notes, 11/20/09 to 12/29/09
4. Health Care Systems, office notes and testing, 2/12/09 to 12/29/2009

INJURED EMPLOYEE CLINICAL HISTORY (Summary):
This individual sustained a lifting injury on xx/xx/xx. Extensive conservative care has been provided, including physical therapy, work hardening, and medications. Individual counseling has been recommended. The patient had back surgery prior to the injury. MRI scan shows a bulge at L5/S1 with right S1 root compromise.

ANALYSIS AND EXPLANATION OF THE DECISION, INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT DECISION:
ODG criteria include absence of other options. Other options have not been exhausted. The patient has not had epidural steroid injections, and she may be a surgical candidate. This criteria is not met. Also, there has not been a thorough evaluation for the chronic pain management program. At the end of the work hardening program, there is a note that the patient should proceed to a chronic pain management program, but there is no rationale for that decision. There has also been a tertiary psychological evaluation that recommended psychological counseling. The evaluation for the pain management program has not met ODG criteria.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR DECISION:
(Check any of the following that were used in the course of your review.)

_____ACOEM-American College of Occupational & Environmental Medicine UM Knowledgebase.
_____AHCPR-Agency for Healthcare Research & Quality Guidelines.
_____DWC-Division of Workers' Compensation Policies or Guidelines.
_____European Guidelines for Management of Chronic Low Back Pain.
_____Interqual Criteria.
_____Medical judgment, clinical experience and expertise in accordance with accepted medical standards.
_____Mercy Center Consensus Conference Guidelines.
_____Milliman Care Guidelines.
__X __ODG-Official Disability Guidelines & Treatment Guidelines.
_____Pressley Reed, The Medical Disability Advisor.
_____Texas Guidelines for Chiropractic Quality Assurance & Practice Parameters.
_____Texas TACADA Guidelines.
_____TMF Screening Criteria Manual.
_____Peer reviewed national accepted medical literature (provide a description).
_____Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)